Regulatory challenges in a complex emergency environment: An update on South Sudan

John Adwok[a], Margaret Eyobo[b], Victoria Achut[b] and Buchay Othom[b]

a Chairman, South Sudan General Medical Council (SSGMC).
b Members, SSGMC.

Correspondence: John Adwok jadwok52@gmail.com

INTRODUCTION

A complex emergency is defined as a situation of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large-scale movements of people, in which any emergency response has to be conducted in a difficult political environment. [1] This was a precise description of the situation in South Sudan until the recent signing of a peace agreement between the warring parties. It is a land locked country with an estimated population of 13 million in 2018. Rebuilding damaged infrastructure and restoring damaged livelihoods will probably last decades.

South Sudan remains a very pertinent example of a 'limited resource' state faced by overwhelming and unprecedented complex emergencies in spite of possessing the third largest oil reserves in sub-Saharan Africa, untapped mineral reserves, massive agricultural potential and abundant water towers. The country gained independence from Sudan in 2011 after a protracted civil war that cost both countries hundreds of thousands of lives. It has some of the worst health care indicators in the world and its formal and informal healthcare sectors remain largely unregulated.

BACKGROUND

South Sudan experienced a devastating civil war from 2013 until recently when an uneasy peace agreement was signed. The war led to an economic, security and political crisis with thousands of internally and externally displaced citizens who continue to have inadequate access to basic services. Of particular concern is the very poor state of health care services and the challenges faced by the regulatory authorities.

Approximately 50% of the 700 medical doctors, dentists and pharmacists in the public sector are not registered with the South Sudan General Medical Council (SSGMC), the official regulatory body for medical doctors, dentists and pharmacists as well as healthcare institutions. Possible reasons for the failure to complete the registration process four years after the establishment of the regulatory body include restricted access to remote parts of the country, inability to cross battle lines in war zones and limited capacity of the centralised regulating government institution.

In addition, ongoing demographic and epidemiological transitions compounded by the security situation have driven rural populations to urban areas (Figure 1). This migration to urban areas in search of security has put a strain on the public health care system and opened the door to an unregulated informal commercial health care sector. We cannot underestimate the challenges of effectively regulating health care services and professionals in an unstable and insecure environment. The SSGMC has not achieved most of its stated strategic objectives that were set out when it was established almost 4 years ago in spite of utilising all the resources available to it. Various regulatory strategies are available to regulate health care and various researchers have reported on their advantages and disadvantages. [2, 3] The regulatory strategy used in South Sudan, as dictated by the SSGMC Act, is the 'Command and Control' strategy administered through state- centred institutions. These state controlled bodies may not often have the capacity or willingness to monitor and enforce health care regulation effectively.

Figure 1. Urban migration in Unity State. (©Dominic Nahr/ MAPS. Published with permission from MSF)

STATEMENT OF THE PROBLEM

Health care regulation through a centralised state institution has not been effective in controlling behaviour in the public and commercialised health care sector in South Sudan as it does not possess the power to monitor and enforce. Limited resources, insecurity and powerful

countervailing commercial incentives that encourage deviant behaviour to continue has rendered the centralised command and control strategy of the state institution ineffective.

DISCUSSION

The quality, nature and cost of health care services provided in private hospitals, clinics, and traditional healing centres remain largely unregulated. Many of these centres enjoy the patronage of powerful personalities with little tolerance to any activity that might undermine their businesses and erode their profits.

Informal Commercialised Health Care Sector

Of particular importance and concern is the role of the informal health care sector, including informal pharmacies and drug retailers. This sector is often the first point of contact for the poor in South Sudan and generally fills the void left by the failing public sector which has also been adversely affected by the deteriorating security situation and financial downturn in recent years (Figure 2).

The country is also experiencing the emergence of a new middle class that has created a demand for better quality and hospital-based care that cannot be provided by the struggling public health care system. Commercial health care provision including the informal sector is an increasingly important source of health care for all socio-economic groups in South Sudan but have remained largely unregulated. This has impacted negatively on the quality and access to health care in South Sudan.

NEGATIVE EFFECTS OF UNREGULATED COMMERCIALIZED HEALTH CARE SYSTEMS

Quality control

When left unregulated, the quality of care from private health care providers remains a major concern, with respect to harmful practices and poor technical quality, especially among informal or non-institutional providers. [4] The quality and type of medications dispensed by some private health care providers is virtually uncontrolled due to linguistic issues and inability to verify credentials. They also enjoy political goodwill and patronage that complicates regulating their activities. There is a strong presence of foreign health care providers in South Sudan working in partnership with local business entities. Efforts to regulate this sector has been a major challenge due to the prevailing insecurity, patronage and system failures.

Information asymmetry

With ineffective central regulation, patients and consumers are unaware of prices or unable to assess quality of care, and this has contributed to supplier-induced demand and increasing costs of healthcare in the country. [4] Provision of medicines and medical care is seen as a business by providers, with increasing consumerist behaviour witnessed among purchasers (Figure 3). The average South Sudanese patient has the misconception that the more expensive a medicine is and especially if it is in injection form, the more effective it is. The informal commercialised providers have cashed in on this misconception and are virtually injecting every patient they see. This behaviour will continue until health care information systems are better regulated and improved.

Figure 2. Commercialised health care provision. Dispensing medicines (© 2018 SSGMC)

Consumer Protection

There is no or little previous or ongoing research to obtain verifiable data on the behaviour of the commercialised formal and informal sectors. Sensational media stories are frequent relating to severe morbidities and mortalities occurring in the commercialised health care sector. Introduction of accreditation systems are still beyond the horizon in South Sudan. Accreditation systems to improve quality of care require the development of complicated regulatory instruments, technical and management capacity. With no official data available on the behaviour and activities of commercial informal health care providers, basic regulatory instruments, such as licensing and registration of facilities and providers remain inadequate and difficult to enforce.

Equity of Access

The few qualified and regulated private health care providers are mostly not accessible or affordable by the poor, who rely on private informal providers that are largely unregulated. [5] This situation underscores the necessity of properly regulating the informal commercial sector to provide effective and safe health services to the poor.

A 2007 study identified a number of factors that make it difficult for regulatory systems to work efficiently and effectively in low and middle-income countries. [6] We have identified four main factors in South Sudan that could be negatively impacting efforts to effectively regulate the health care sector in the country:

- Lack of institutional development with skilled personnel and dedicated departments or units, appropriately equipped to enforce rules.
- Poor enforcement due to inadequate monitoring and information systems as well as mechanisms for decision making about violations and guidelines on when and how to apply sanctions.
- Difficulties in managing the medical profession due to underdevelopment of medical associations that self-regulate the profession to supplement the regulatory instruments such as licensing and registration.
- The quality of education, training and continued professional development of medical doctors, dentists and pharmacists is poorly monitored.

CONCLUSION

The centralised bureaucratic regulatory model of health care may not be appropriate in a country with limited resources experiencing complex emergencies and unable to control deviant behaviour. Critically analysing the institutions and dynamics of other existing regulatory systems is required with the aim of developing hybrid more effective and efficient systems that would be more suited to South Sudan and perhaps other countries in similar situations. There is empirical research evidence that indicates regulatory models used in developed countries or inherited from colonial systems are not suitable for countries experiencing complex emergencies and a break down in the rule of law and order.

Targeted research to provide evidence on the efficacy of low cost decentralised approaches that involve a mix of regulatory strategies by state, private and civil society actors is needed. The findings would guide policy makers in reforming current inefficient health care regulatory systems in fragile states besieged by complex emergencies.

References

1. World health Organization. Environmental health in emergencies and disasters: a practical guide; 2002. http://www.who.int/environmental_health_emergencies/complex_emergencies/en/

Figure 3. Information asymmetry. (© 2018 SSGMC).

2. Akhtar A. Health care regulation in low-and middle-income countries: a review of the literature. Health policy and health finance knowledge hub working paper series, 14, 2011.
3. Saltman RB, Busse R. Balancing regulation and entrepreneurialism in Europe's health sector: theory and practice. Regulating entrepreneurial behaviour in European health care systems, 3, 2002.
4. Bloom G, Kanjilal B, Peters DH. Health Affairs (Millwood) July-Aug; Regulating health care markets in China and India. 2008; 27(4): 952–963. doi: 10.1377/hlthaff.27.4.952
5. Purohit BC. Private initiatives and policy options: recent health system experience in India. Health policy and planning 2001;16(1), 87-97.
6. Ensor T, Weinzierl S. Soc Sci Med. Jul; 65(2): Regulating health care in low- and middle-income countries: Broadening the policy response in resource constrained environments 2007; 355–366. Published online 2007 Apr 23. doi: 10.1016/j.socscimed.2007.03.021

This article is based on a presentation given by John Adwok at the International Association of Medical Regulatory Authorities in Dubai in October 2018. Co-authors participated in sourcing data for the presentation.